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Foreign aid, Cashgate and trusting relationships

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Foreign aid, Cashgate and trusting relationships: key factors contributing to (mal) functioning of the Malawian health system.

Abstract

Background: Malawi has a long history of receiving foreign aid for its health and other services provision. In the past two decades foreign aid, both monetary and technical support, has increased, with the aim of the country being able to achieve its Millennium Development Goals by the end of 2015. It is currently moving towards achieving the Sustainable Development Goals. Despite increased donor support, progress in the Malawian health service has remained very slow.

Aim: to discuss how trusting relationships amongst the stakeholders is vital in proper financial management, including of foreign aid and effective functioning of the health system in Malawi.

Method: this paper is based on a qualitative study, using a range of research approaches: the in-depth case study of foreign aid funded Maternal and Child Health (MCH) projects (n=4); Key Informant Interviews (n=20) and reviews of policy documents to explore the issues around foreign aid and MCH services in Malawi.

Findings: During the study period 2014-16, the country continued to face significant financial and other resource management challenges. The study has identified key factors, notably the issue of financial mismanagement, particularly Cashgate, news of which broke in 2013. This scandal has resulted in a great deal of mistrust amongst key stakeholders in health. The concomitant deterioration of working relationships has had a major impact on the health system resulting in further mal-distribution of resources and programme duplications. After highlighting key issues around foreign aid, Cashgate, and trusting relationships amongst stakeholders, this paper makes policy suggestions, with the aim of assisting donors and External Development Partners to better understand Malawian socio-political networks and relationships amongst key stakeholders. This understanding will help all those involved in the effective financial management and dispersal of foreign aid.

Introduction

This paper discusses factors that play crucial roles in the effective functioning of Malawi's health system: 1) effective financial management including the management of foreign aid and 2) existing socio-political networks and relationships amongst major stakeholders, including External Development Partners (EDPs). **Trust and proper coordination amongst stakeholders, which is required for these factors to function well, occupies the core part of the debate in this.**

Health system financing (or effective financial management) has been widely known as one of the building blocks of any health system. Another health system building block is *leadership and governance* (WHO 2007), which is influenced by socio-political context and networks and relationships amongst key stakeholders. An understanding of these elements is particularly important for Malawi because, in the past several decades, there has been a phenomenal amount of foreign aid support for the country's economic development, including the provision of a basic universal health service and raising basic living standards. Yet progress has been painfully slow.

EDPs come to Malawi, as to any other low-income country, to deliver development: to improve people's living standards and alleviate poverty. They may come with humanitarian intentions or with strategic commercial interests. Realizing the phenomenal increase in EDPs involved in international development, there are policy and practical efforts for better coordination amongst stakeholders. Unfortunately, even after the Paris Declaration in 2005, which was to promote better donor coordination and aid specialisation, this has not improved, but instead the situation in Malawi has deteriorated (Nunnenkamp *et. al* 2016). Currently, EDPs in Malawi seem to lack trust on the functioning of the government system, which impacts negatively on EDP coordination.

Being economically disadvantaged country, EDPs have been playing a major role in health service provision in Malawi since its independence in 1964. While Malawi is considered one of the most peaceful countries in sub-Saharan Africa, it faces long-standing political, fiscal, and health system challenges (Gabay 2014; Shawa 2012; Sida 2005). Since the new "more democratic" government of 1994,ⁱ there have been further

efforts by those EDPs supporting the Malawian Government in identifying priority areas in health, and in various other sectors of development, and allocating resources accordingly. In addition, since 2000, there have been reforms in the public finance management system to make for a more effective use of resources, (Folscher *et al.* 2012).

As of early 2018, at the time of writing this paper, health and most other human development indicators, suggest Malawi's progress is lagging behind. Life expectancy at birth remains low (55.5 years male and 58.2 female in 2015, (GoM 2016)). A vast majority of children suffer from malnutrition and human lives are lost unnecessarily to preventable disease conditions (Countdown to 2015, 2015). The high prevalence of Malaria, Tuberculosis, HIV/ AIDS and other communicable diseases have further burdened an already overstretched health system (Zere *et al.* 2010). The critical shortage of health professionals in the country has been a crucial factor crippling the health system (Grigulis 2010; Adamson 2006; Palmer 2006). Despite a significant amount of international support, the slow economic growth and poor health service provision have combined to cause much frustration amongst foreign aid donors and EDPs, and the vast majority of the Malawian people, not only those who are involved in health service but also the general public.ⁱⁱ

In addition to its failure to meet public expectations, the Malawian government has been facing international pressure to meet global development goals, including the achievement of the Millennium Development Goals (MDGs), decided at the Millennium Summit in 2000. At that time, country specific targets were set and were to be achieved by 2015.ⁱⁱⁱ The health budget needed to be increased for them to be achieved. Malawi indeed was one of the signatories of the Abuja Declaration, which encouraged governments in African Union countries to increase their health budgets to 15% of their national expenditure (WHO 2011). However, in 2014/15 and 2015/16, the Government expenditure on health has been only 11.2% of total Government expenditure (GoM 2015), which fails to meet the Abuja target.

Foreign aid and international assistance have been crucial in the effort for Malawi to meet those MDG targets and overcome its long-standing development challenges (Gabay 2014). A United States Agency for International Development (USAID) fact sheet

suggests that international donors contribute a significant amount towards the government health budget, thus making Malawi one of the most foreign aid-dependent countries in the world (USAID 2015). A recent Resource Mapping exercise carried out by the Clinton Health Access Initiative, (CHAI) in Malawi, echoed this finding. It suggests that 81% of the country's total health expenditure and 99% of its HIV expenditure comes from foreign donors (CHAI 2015).

Trust amongst stakeholders, the service providers and service users and other institutional partners across the board, is vital for the proper functioning and utilisation of a health system (Rowe and Calnan 2006). Unfortunately, any abusive transaction, such as bribery, or corruption of resources, within the system can further damage a trust (Tibandebage and Mackintosh, 2005). Financial mismanagement and fraud have been major issues in Malawi for some time (Shawa 2012; Booth *et al.* 2006; Sida 2004). Unfortunately the acute and reverberative problem of the 'Cashgate' scandal, which broke in the summer of 2013, has further complicated the financing of the country's health sector, and the government's overall financial management system. Senior civil servants, politicians and private business contractors (those supplying goods and services to the government) have been found to be involved in vast amounts of fraud and the misuse of Government funds for personal benefit (Baker 2014; Gabay 2014).

Research method

This paper is based on a qualitative study aiming to generate policy-relevant knowledge on the roles and functions of foreign aid related institutions, be they donors, intermediaries or local implementing partners, in MCH service development and delivery in Malawi. The study is extensive, but the data presented in this paper is directly related to issues around the management of foreign aid, and stakeholders' network, relationships and trust in health system functioning in Malawi.

Fieldwork and data collection processes

Data were collected using a number of qualitative research approaches. We began the study with a stakeholder mapping exercise, for which we had developed guidelines. The two main criteria were: 1) to chart all foreign aid funded MCH projects in Malawi, and 2) specifically those who have been working in the country from the 1990s to 2016, either

via the Government system or outwith it. We reviewed all available data sets, policy documents, literature, and also pursued word of mouth recommendations.^{iv} After compiling a list of stakeholders involved in MCH, we ran an inception workshop, inviting people from key stakeholder organisations identified as donors or intermediaries, be they national or local implementing partners in the country. This facilitated our entry to the field, and allowed us to gain a broader understanding of foreign aid and MCH services, and to verify and update the list of stakeholders.

From the list of stakeholders involved in MCH, we selected four projects for in-depth study.^v Selection criteria were: 1) organisations working in the MCH field, 2) those funded by foreign aid, and 3) a willingness to participate in the study. We also wanted to capture the diversity of organisations: such as large and small funders and projects working in different geographical locations in Malawi.^{vi}

After selecting four MCH projects for in-depth case study, we visited the project implementing sites, spending some time with field staff to gain a deeper understanding as to how these projects were run.^{vii} We also interviewed staff members involved in each project, with a particular focus on how they receive foreign aid, and how money is channeled to carry out MCH activities. In total, we conducted Key Informant Interviews (KII) (n=20), with government policy makers, donors, independent consultants working in the MCH sector and staff working in intermediary organisations. In addition, we also attended stakeholder-meetings (n=13) and attended and observed foreign aid funded training and evaluation programmes (n=3).

During our field visits to case study sites in various districts, we kept field notes, recording all key observations we made on the everyday functioning of the MCH projects, and of any activities we noted that yielded findings related to foreign aid in the MCH sector. Undertaking these in-depth case studies of our selected four foreign aid funded MCH projects has allowed us to produce detailed data on discourses around foreign aid, donor behaviours and strategies used by intermediary organisations in Malawi.^{viii}

Additionally, we have reviewed and analysed national media reporting, specifically the national newspaper *Nation*, and the *Malawi Times*, with a particular focus on foreign aid,

Cashgate, networks and relationships during the study period (2014-2016). Some of the discourses we present in the findings section are based on the documentary analysis.

Information gathered in this study has been the result of a long-term engagement with major stakeholders involved in MCH service provision in Malawi, including foreign aid donors, staff members in the Government of Malawi health systems, and intermediaries and beneficiaries of current MCH projects.

Research team members consisted of Malawian and UK researchers. We worked together to gather data, and conducted monthly meeting to discuss and analyse emerging themes and findings. We have made all possible efforts to minimize potential biases, via team members working together while conducting interviews and making field trips, and through discussing findings together. At the same time, Malawian team members who have had longer term engagement in the health system there, were found to be very helpful in navigating the complex bureaucratic processes involved in accessing research sites and understanding socio-cultural nuances and Malawian working culture.

Data analysis

All 20 interviews (KII) were digitally recorded, and were later transcribed and translated. Our field observation notes too were recorded, and we read and re-read our notes thereafter to analyse data. We also analysed relevant policy documents and the media coverage on foreign aid and MCH in Malawi. We held monthly meetings during which emerging themes were identified. We discussed our progress in the data-gathering process and, in addition to monthly meetings and regular discussion we organised a two-day mid-term workshop as a further check of our progress. At this time we systematically discussed all data from each of our case study projects, including KII in detail. All six of the Malawi-based research team members participated in data analysis, and information was verified and crosschecked by each member for its validity.

Ethical consideration

Ethical clearance was obtained from the authors' institute, which is based in the UK and from the College of Medicine Research Ethic Committee (COMREC) in Malawi. Informed consent was obtained from all individuals and institutions involved. Apart from the information that was in the public sphere, individual informants were anonymised to protect their identity.

Conducting research in the aftermath of 'Cashgate', and during its investigation, has been both a positive and a negative experience for the researcher(s). One positive aspect is that there has been much news and discussion of the scandal in the media, as well as in the public sphere. The corruption has been publicised widely. However many people have been cautious during interview, indeed reluctant to fully discuss anything sensitive bordering on their personal or institutional space.^{ix}

Research findings

Before discussing the main research findings, it is useful to briefly understand the broader context of Malawi's health service development in the past two decades. After setting the health service scenario, we discuss the main themes: health system financing and management, networks and relationships amongst stakeholders and how trust play key roles in the effective functioning of the health system in the country.

Structure of the health service in Malawi

At the dawn of the new millennium there had been a major international push in Malawi, as in other low-income countries, towards the achievement of its MDG targets by 2015. In 2004, after the change of the political system, the new government, led by the now-late Bingu Wa Mutharika, felt that the health system was not functioning effectively. There was chronic and widespread corruption in the country's financial management systems, which was affecting the health system too. Many foreign aid funded health and development activities were un-coordinated. At that point the new government attempted to crackdown on the widespread corruption and make improvements in the public financing system (Shawa 2012). This was ultimately expected to have a positive impact on health service financing.

In an attempt to harmonise foreign aid funded programmes, including MCH services, and empower the local government in service delivery, the government of Malawi decentralised the health system in 2004. After this, for the first six years (2004-2010), the government adapted a Sector Wide Approach (SWAP) with the aim of gaining a comprehensive picture of all international funding and making the functioning of EDPs more transparent, so that resources could be allocated fairly across the country (Zera *et al.* 2010).

Decentralisation of the country's governance and the introduction of SWAP coincided with a wider global shift on foreign aid management mechanisms, within neoliberal frameworks and result-oriented development processes (Banerjee and Duflo 2011). In theory what the Government of Malawi sought seemed an ideal situation for, as one of our key informants working in the Ministry of Health stated:^x

“...Before the implementation of SWAP, donors would engage in need identification independently and make priorities, so the whole management approach [in health sector in particular] was somewhat fragmented, and un-coordinated”.

Decentralisation was about giving more autonomy and responsibility to the District Health Office (DHO) to plan and manage health services and the budget at the district level. In order to support the DHO, and facilitate its smooth functioning, District Health Assemblies (DHAs) were set up in all 28 districts. Since that time the DHAs have been responsible for planning, prioritising and implementing health programmes, in harmony. In addition to the 28 DHOs, four main tertiary care referral hospitals have been given the autonomy to plan and deliver health services in their own areas.^{xi}

In order to provide strategic support and guidelines for all DHOs and tertiary care hospitals in the country, the National Health Service Strategy Plan (NHSSP) was developed in 2011, with the help of EDPs in Malawi. This document is used by all 28 DHAs and DHOs and the four central referral hospitals when making their Annual Health Plans.

Outside the government system, there are a number of other major stakeholders making a significant contribution to the Malawian health system. The Christian Health Association of Malawi (CHAM), a faith-based organisation, has played a vital role in

health service provision in the country since Malawi's independence from the British in 1964. In 2006, in order to avoid duplication and provide better service coverage, the government made a service level agreement with CHAM. CHAM has worked alongside the government service provision, serving mostly in rural and under-served areas. Currently CHAM facilities provide approximately 37% of the country's health services, the government provides over 60% and the remainder is contributed by the private sector (Manthulu 2014).^{xii}

[Map of Malawi with districts]

Health system financing and foreign aid

In terms of financial planning of the health programmes, all of the 28 DHOs and the four major hospitals prepare an annual District Health Plan and budget with their DHAs. The plans then go to the Parliamentary Health Committee (PHC). District and referral hospital health service plans and budgets are approved at the PHC. DHOs and hospitals receive a certain amount of funds thereafter directly from central government.

Once funds are in place, the DHAs are responsible both for allocating resources according to the available funding for that district, and also for prioritising service needs. However, despite having much autonomy and responsibility, DHOs are not directly accountable to the Ministry of Health (MoH), or the Health Secretary at central level, but they are accountable to DHAs. The leader of each DHA is charged with reporting the district health situation directly to the PHC.

The main challenge to meeting health related MDGs has been a chronic shortage of resources at all levels of the health service: namely the shortage of health professionals, drugs (even basic ones) and other supplies (Grigulis 2010; WHO GHWA 2008; Adamson 2006; Palmer 2006). In June - July 2015, a lack of funds caused a major crisis in the health service. News and reports emerged about many DHOs having no money to buy drugs, no money even to buy fuel for ambulances and provide other emergency services, and finally no money even to purchase essential supplies at the health facilities. One example of this crisis occurred in July 2015, when the headlines of the *Malawi News*, a national daily newspaper, read "*Funding Crisis Hits Govt Hard: Fails to*

pay MPs fuel allowances as hospitals run dry of drugs” (Malawi News 2015a). This article went on to suggest:

“...the serious funding crisis in the DPP [Democratic People’s Party] government that has seen, amongst others, public hospitals having no drugs or fuel for ambulances, has not spared member of parliaments (MPs). MPs fuel allowance has been slashed half in June [2015]”.

This is just one example illustrating the severity of the health service-funding crisis Malawian DHOs were facing in the summer of 2015. We verified this news statement with at least two DHOs during field visit in July 2015.

While the international donors contribute a significant amount of aid to the Government health system in Malawi, it is very important to note that the government system in fact meets only about 20% of overall health resources in the country. Independent service providers: charities, Non-Governmental Organisations [NGOs], International [I] NGOs and the private sector, provide 80% of the country’s health resources. As an officer at the Ministry of Health identified:^{xiii}

“...Estimated only about 20% health resources that is being used in Malawi goes through the government system and the rest 80% outside the government [meaning used by NGOs and INGOs].^{xiv} The resource invested outside the government system is highly uncoordinated, and there is much duplication in there...”

Cashgate and government - EDP relationships

While many EDPs and international donors, providing direct financial assistance to the government, can now appear apprehensive and to have lost trust in the government’s financing mechanisms, they nevertheless do seem to be very committed to Malawi’s development. For example, soon after the ‘Cashgate’ scandal broke in September 2013, some of the key donors, such as DFID UK and Norad (Norwegian aid), withdrew from funding through the government system, but then started channelling funds through various NGOs and INGOs, and through private contractors, thus continuing their support to the Malawian health system. The statement below, by a Malawi government official, makes this point.^{xv}

“...After the ‘Cashgate’ scandal, some donors decided not to put money in government system, they started channeling funds outside the government system and then the recently developed NHSSP [National Health System Strengthening Programme] suffered...”

He continued:

“... and only recently, Norway and Flanders have started putting money back in the government system, but their accounts are kept separately, so they can be examined or audited separately...”

Almost two years later, in the summer of 2015, some of those donors, who had initially withdrawn from funding the government, have resumed their commitment to funding through the government system. Now however, they wish to maintain a separate financial record of their funding, **which shows they lack the trust in the Government system.**

By observing EDPs’ current actions, one can say that the relationship between EDPs and the Malawian government is cautiously positive. Donors are wary but committed to supporting the Malawian government and the government is, as ever, increasingly dependent on external help. As suggested by the Malawi Government officer (above) the ‘Cashgate’ scandal has certainly further damaged the trust between the donors, EDPs and the government of Malawi. The trend of carefully bypassing the government system continues while providing assistance for health and development programmes through the other intermediaries.

The SWAP was in fact abandoned and became inactive in 2013, soon after the Cashgate scandal broke. Resource Mapping exercises have been conducted since 2011, by the DoH with the help of CHAI, initially to provide comprehensive information to continue the role and function of SWAP, and to gain a clearer picture of donor funded activities in the health sector, so that the NHSSP can guide DHOs and other planners, which has the potential to guide the EDPs and the government to avoid any such duplication.

Programme duplication due to mistrust amongst key stakeholders

The decentralisation of health services in 2004 and the introduction of SWAP has not resolved all the issues around foreign aid funded programme duplication, for it still existed in 2016 (during the study period). With Malawi perceived as one of the poorest

countries in sub-Saharan Africa, desperately needing external help for its economic development, as suggested by human development indicators (such as poverty, illiteracy, and high prevalence of communicable diseases as noted above), there is a great deal of international interest in supporting the country. An increasing number of international players are involved in health service development and delivery now. Because of government bureaucracy and the mechanism of health system governance, as described above, there are loopholes in the system that can be exploited, perhaps unintentionally, by EDPs. Duplication around health service provision, funded and managed by international donors and EDPs and provided outside the government system, is the consequence.

We were informed of this thus:^{xvi}

...If a donor or an EDP wants to start a health service in a disadvantaged part of Malawi, they can easily bypass the Ministry of Health (MoH) and go straight to the DHO. In theory however, a programme related to maternal and child health should collaborate with the Reproductive Health Unit (RHU) within the Ministry of Health, but there is no straightforward mechanism to monitor all activities of foreign aid funded programmes that function without proper consultation with the RHU. As a result of this, foreign aid funded projects are highly uncoordinated with much duplication of project funding and implementation...

However, EDPs and other donors have their own version of the story. Some donors and EDPs are unsure why the DHOs/ DHAs would not have a clear record and monitoring mechanism of what is happening in the district, in order to avoid any major duplication. This problem has been clearly articulated during researchers' interactions with the stakeholders involved in foreign aid and MCH services provision in Malawi. The fieldnotes of one of the researcher's below highlights an EDP's concerns about this.^{xvii}

"...There are too many INGOs [International non-governmental organisations] working [in same sector and engaging in similar activities] in Malawi now, they [meaning EDPs] do not seem to communicate with each other. JR [name changed] has heard a rumor that it was deliberately kept that way [by local partners to ensure income from multiple sources] so funding does not get curtailed. Local professionals are involved in multiple roles, so they have multiple income sources..."

A further, and often-quoted, example by many of our informants is that districts similar to Mangochi, Salima and Dedza, those nearer the southern shore of Lake Malawi (see

map above), have more NGOs and INGOs involved in development projects including MCH ones, because of their beautiful locations, easy access to major road networks and other facilities. Many organisations are therefore doing the same job without coordinating with others in the same area. Conversely northern and remote districts do not receive equal amounts of resources and services from EDPs. While SWAP meant to address these issues, it was not fully effective because of the country's already-cited financial and political situation.

From our ethnographic observation sessions (attending stakeholders meetings) we witnessed some important strategic efforts made to coordinate health sector programmes amongst the various stakeholders: foreign aid donors, government representatives and project implementing partners in Malawi. Such coordination takes place in the form of an annual review of the health projects, through establishing various working groups and by resource mapping exercises. However, this is evidently not fully effective, as rampant programme or project duplication still exists in districts, due to ineffective coordination and lack of trust amongst stakeholders.

Where does the foreign aid go?

During our interaction with stakeholders, a frequently heard comment on how foreign aid is spent in Malawi is that the money is spent in running workshops and meetings, and providing participants with accommodation in luxury hotels and resorts and offering *per diem* remuneration. While attending training sessions, and regular stakeholders meetings, as part of our participant observation sessions, researcher(s) on numerous occasions encountered participants expressing unhappiness about the amount of *per diem* they were offered (or not offered) for attending meetings and training sessions. The *per diem* seems to be regarded as additional income by health professionals.

We can offer many examples from our field observation that further clarify the situation. While attending a quarterly stakeholders' meeting, one of the researchers witnessed the discussion of a trainer, involved in providing training to health workers, on saving mothers' and babies' lives in an emergency, about the *per diem* system: xviii

“... SSDI [Support for Service Delivery Integration - Malawi]^{xix} pays a handsome *per diem*, so participants will prefer to attend SSDI-run programmes. There is an urgent need for the Ministry of Health to standardise *per diem* at the national level, so all institutions and organisations follow national guidelines...”

There have been numerous such situations witnessed during our fieldwork. During an informal discussion about foreign aid in Malawi, a university professor who worked in Northern Malawi shared this perception:^{xx}

“...Also, donors come with their own agendas: supposing they are giving Malawi 10 million Pounds, but donors will come up with their own contractors and ways to use this money by themselves, such as flights and seminars in expensive hotels and holiday resorts. Then by the time money gets to the public, it will be only about £3 million. But in paper it will be seen as £10 million given to Malawi. This is one of the main problems...”

When the researcher further enquired about the national politics and current ‘Cashgate’ scandal, this professor added:

“...there are many irregularities here, but the donors and external observers have no clue, they can only see things on surface. All covered up and so all looks rosy and fine to them. Not many donors fully get it. And they don’t get the importance of kinship relationships in Malawi...”

Why is it important for EDPs to understand relationships, and the local socio-cultural and political context in Malawi while trying to support its development? Perhaps this does not seem very relevant to outsiders at first, but again might it not be useful, or even be very important, to understand kinship and other socio-political relationships and trust and to have therefore a deeper insight into political and economic processes, imperative to health service functioning in the country? We argue that it is.

Socio-political relationships and trust: formal and informal

We would suggest consequently that what is meant and understood by social and political relationships, which often includes kinship in the context to which the Malawian professor referred, must be explored and unpacked. The concept of kinship relationships discussed here is not just about family, kin or blood relationships, but must be expanded further to include a wider group of professional and political elites. These are, more specifically, small but privilege groups of political elites, usually those

of the ruling class working in the government and development sectors in Malawi. This extended version of kinship group share similar socio-cultural values, friendships and trust, and mingle in Malawian policy circles. From the researchers' engagement with this group during fieldwork, it was identified that many of them went to the same school, attended the same church, and that now their children go to those same schools.

Rakner *et al's*, research, entitled "The budget as theatre - the formal and informal institutional makings of the budget process in Malawi" stated:

"... Malawi is one of the most unequal countries in the world with an extremely small elite that simultaneously controls both the political and economic spheres of Malawi. The interests of the elite often converge beyond political divisions thereby preventing poor people from having a voice. For example, both the ruling party and opposition MPs have businesses in large-scale farming, transport, tobacco, fertilizer, and construction. There is no alternative group of elites articulating a different economic agenda since the political elite often are the major business owners..." (2004; p8)

This statement seemed to still hold true in 2015-16, for as one of us noted in our ethnographic field notes of 25 March 2015:

"...What I learn more and more is that a few people are closely associated with foreign aid, and that an institution called Garima (name changed) is a major site of inflow of foreign aid, as I later learned from one of our case studies that they are collaborating with AA, a national NGO (name changed), and Garima in a project looking at adolescent health projects ..."

Such collaborations between two institutions, which we found out are run by two long-term trusted friends, are very common in Malawi. During research fieldwork many key people and institutions were seen to be involved in multiple activities, confirming the findings of Rakner *et al's* research cited above. While attending stakeholders' meetings, we noted the same circle of people attending many of these different meetings. Stories have circulated too of foreign aid donors approaching the tight-knit, small but *trusted* and powerful, Malawian social and political elites to discuss funding applications that meet the donors' funding priorities, and of grants being awarded thereafter. These trusted-relationships are in fact key to the functioning of foreign aid funded activities within Malawi.

On the 25th of July 2015, a news headline in a Malawian national daily newspaper read, *“NAC [National Aid Commission] - global fund saga effects trickle to MACRO (Malawi AIDS Counseling and Resource Organization)”* (Malawi News 2015b).

This article was about Global Fund money. According to the article, MACRO had been receiving Global Fund money through NAC and in fact the Global Fund had stopped funding NAC (of Malawi) because of a suspected misuse of those funds. The piece further stated:

“...NAC disbursed K 5 million funding to beautify Malawi (Beam) trust, belonging to first lady Gertrude Mutharika and K9 million to an ethnic grouping Muthakho wa alholmewe, yet the two organisations are not directly associated with the fight against HIV and AIDS pandemic” (Malawi News 2015b).

The story went on to suggest that there has been a true misuse of Global Funds, with aid money being channeled towards funding trusted organisations, run by a small group of social elites, most of whom were connected to each other; socio-culturally, professionally, politically as well as through family relationships.

Discussion and concluding remarks

The findings above highlight not only money, and expert professionals but also trusting relationships amongst the major stakeholders, are needed for the effective functioning of a health system. In Malawi, many EDPs appear to have lost trust in politics and the government's financial management system. As a result some of the key donors, such as the DFID UK and Flanders, have withdrawn their direct financial support for government provision of basic health services, and started exploring alternative ways to support Malawi. A culture of mistrust has grown and this has got worse mainly since Cashgate. Despite lacking trust in the government finances and the proper use of foreign aid in Malawi, many international donors and EDPs appear very committed to supporting Malawi's health service and other infrastructural development.^{xxi}

While the waste of resources in the health system is a global concern (WHO 2010), the misuse of funds (as in 'Cashgate') and programme duplication is leading to a further waste of resources. This has added stress to Malawi's already fragile and overstretched health system. As the Malawian government officer stated above, 80% of the total

resources spent in the health service now is channeled outwith the government system, and the vast majority of these resources are financed by foreign aid. This means that EDPs and foreign aid stakeholders can play critical roles in minimising the wastage in the health system, by avoiding programme duplication, which can be achieved by effective donor coordination.

There seem to be discrepancies between the usually rather idealistic donor expectations and the everyday practical realities of the how the Malawian social system functions. EDPs try to influence the country's health system with their ideas of what constitutes international development, and through offering their support in the running of projects, these are usually short-term and result orientated. EDPs relationship with the project is immediate, as can be seen in the increasing use of result-based financing frameworks. When the funding for a project finishes, all project activities have to be completed and terminated. Thereafter the donor will move away to a new area, or another project will come there, which will be funded by perhaps a new donor. There is very little longer-term donor commitment.

On the other hand, the Malawian system has its own in-built trusting mechanism, be it based on kinship, friendship or relationship networks or political patronage. Another major issue discussed in the paper is the apparent gap in understanding by some donors, who enter Malawi with the aim of rescuing a Malawian health system, at speed and without a proper understanding of how the trust and relationships works in the country. This 'top-down' approach has resulted in programme duplication in some districts and a lack of funding and service provision in others. There are formal (ideal) and informal (practical) norms that operate in international development policy and the everyday functioning of the system (Olivier de Sardan, 2008). They have their own style of running the country and development projects, which will go on despite the donors' effort to influence the government. This paper also highlights the fact that Malawi indeed has a very small group of social and political elites, and most of the members are connected to each other in various ways, engaging in close group of political elites and kinship as suggested by Rakner *et. al* (2004), over a decade ago, seems relevant in 2014-2016.

This paper has clearly illustrated how important it is for any outsider (EDPs) to understand socio-political relationships and networks, if they wish to mobilise development resources in a sensitive manner to achieve overall global development goals. Development professionals understand the Malawian system, to better navigate a complex bureaucratic process, and set realistic expectations and outcomes. It is, at its heart, a question of what the donors and EDPs can learn from the government and vice versa. An important lesson for all stakeholders is that trusting relationships, donor networks and coordination are vital for successful development projects, which will help to make a maximum use of the scarce resources, so those who need them most are benefitted (Smith and Rodriguez 2015; Justice 1986). Consequently EDPs must coordinate amongst themselves, plan and channel their funding, after proper consultation with central government and DHOs. Involving service users and engaging with the central government in service planning can avoid programme duplication.

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ⁱ When compared with the dictatorial nature of Banda's government

ⁱⁱ The term 'Foreign aid donors' means those governments and institutions who provide funding and other technical assistance. 'EDP' refers on the other hand to external institutions working in the field of development: donors, intermediaries, and related institutions.

ⁱⁱⁱ Three out of eight of the MDGs (numbers 4, 5 and 6) were related to health: to reduce child mortality; to improve maternal health; and to combat HIV/ AIDS, Malaria and other diseases.

^{iv} We used word-of-mouth strategy, because not all foreign aid funded projects were included in record.

^v Four case study projects were: 1) Malawi Obstetric Teaching and Training in Emergency (MOTTIE – (funded by Scottish Government, managed by University of Dundee in collaboration with Malawian health experts), 2) Family planning including safe abortion service (funded by Department of International Development UK (DFID), managed by UN Population Fund (UNFPA) and implemented by Banja La Mtsogolo (BLM)), 3). Helping Babies Breathe and Helping Mothers Survive Bleeding After Birth (Funded by USAID through ABT Associates, managed by Association of Malawian Midwives – AMAMI) and 4) Nutrition project (funded by DFID and managed by Clinton health Initiatives (CHAI) implemented by Development Aid from People to People - DAPP Malawi).

^{vi} The selected four case studies are all foreign aid funded Maternal and Child Health Projects. Two of these projects currently engage in capacity building in order to improve maternal and child health services in Malawi and the other two provide direct services to improve maternal and child health.

^{vii} In this paper the word 'project' refers to a particular activity or activities designed to achieve certain aims, and is usually short term, and time-bound. A 'programme' denotes a longer-term process, with perhaps multiple stages and the possibility to continue for longer periods with additional funds. Three out of four MCH case study organisations were projects and one was a programme. However in this paper we use the term 'project', which also includes MCH programmes.

^{viii} These included training sessions on neonatal resuscitation, management of post-partum haemorrhage and nutrition education.

^{ix} This has been an uncertain time for many stakeholders involved in foreign aid and Malawi's health sector development. There were some donors who had withdrawn their support to the government. The timing of the study, immediately after the exposure of Cashgate, may have some impact on the validity and reliability of findings of this study.

^x Key Informant Interview, Malawi, on 21st July 2015

^{xi} The tertiary care referral hospitals are, Mzuzu Central Hospital, Kamuzu Central Hospital Lilongwe, Queen Elizabeth Central Hospital in Blantyre and Zomba Central Hospital

^{xii} In the absence of universal coverage in healthcare, household out of pocket spending for health is common in Malawi. However, it is important to note that with donor commitment and support towards universal coverage, in the past two decades, out of pocket household spending in health is reported to have decreased significantly from 26% in 1998/99 to 12.1% in 2005/2006, which remained 12% in 2013, relieving this debilitating burden on economically disadvantaged households (Mamaya 2015; Mwandira 2011; Zere *et al.* 2010).

^{xiii} Key Informant Interview at the Ministry of Health, Capital Hill, Lilongwe, Malawi, 20th July 2015

^{xiv} We can understand this now, in that while all of our four selected case study projects work in collaboration with the government system, resources involved in these projects are channeled outside the government system.

^{xv} Key Informant Interview, Ministry of Health, Capital Hill, Lilongwe, 21st July 2015

^{xvi} Key Informant Interview, Lilongwe, Malawi, July 2015

^{xvii} Noted in research field notes during an interaction with a Malawian External Development Partner, May 2014.

^{xviii} Ethnographic observational note of a stakeholder meeting in Lilongwe, Malawi, on 18th July 2014

^{xix} SSDI is a contracting group that works with foreign aid funded health projects, in many low-income countries.

^{xx} Personal communication with a university professor, on 22nd July 2014, Lilongwe, Malawi

^{xxi} Witness the pledge, made at the Millennium Summit of 2000, and at various G8 and G20 meetings afterwards, to contribute 0.7% of their Gross National Product, whatever the amount, towards overseas development assistance.